

Reflections on the Great Flu Pandemic of 1918

by Jeremy James



5G antenna.

The pandemic scare in Wuhan, China, is clearly a critical event for the world as a whole. Unfortunately, the main source of information about developments in China is the Chinese Communist Party (CCP), an organization which cannot be trusted to speak truthfully about anything. Even in cases where video reports have been transmitted to the West by individual Chinese citizens, it is almost impossible to ascertain whether they are genuine. While the context and the emotional content of many is very compelling, we cannot rule out the possibility that they may serve some wider purpose. The CCP propaganda machine is highly sophisticated and well capable of producing material of this kind, if only to mislead their own people.

The narrative which we in the West are expected to believe is broadly as follows:

Based on official reports to date, as well as opinions widely expressed in Western media, the corona virus is a highly contagious and potentially fatal disease which is spreading rapidly within China. Draconian attempts by the Chinese government to contain the virus may be slowing its advance to some degree, but as more and more cases are identified internationally, there are concerns that the city-wide shut-downs seen in China may need to be introduced by neighboring countries such as S Korea and Japan. Similar steps may need to be taken elsewhere before very long. Italy, for example, has restricted public mobility in a number of northern towns. Scientists are working on a vaccine which, if it proves to be effective in preventing or curing the disease, will likely be made available by the World Health Organization, possibly on a mandatory basis in the countries most affected.

But is any of this true?

If we are to analyze this scenario and test it for accuracy, we should first ask some searching questions about an earlier pandemic – the most devastating in modern history – known as the ‘Spanish Flu’ of 1918. Surprisingly, a hundred years after that awful event, many important questions about its origin and its effects have yet to be answered. As two medical specialists stated in 2006:

“Many questions about its origins, its unusual epidemiologic features, and the basis of its pathogenicity remain unanswered.”

– J K Taubenberger & D M Morens, *1918 Influenza: The Mother of all Pandemics*, Emerging Infectious Diseases, January 2006.

Origin

The geographical origin of the great flu pandemic of 1918 ought to be a well established fact, but it’s not. A new, more virulent strain of flu normally develops in a specific location and then spreads out gradually from that location. The disease was first observed in January 1918, but at locations that were thousands of miles apart – northern France and Kansas. The simultaneous appearance of a new strain in two disparate locations is very difficult to explain using the standard epidemiological model.

Some experts and medical historians claim the outbreak first started in northern France (at a troop staging post) and spread out from there. Others claimed it first started in Kansas, seemingly in a military camp located in that state. Another expert claimed it started in China but an acquired immunity among the Chinese population meant that it was not noticed until it reached the United States, and spread from there to northern France.



What is interesting about the various theories is that the proposed place of origin is strongly associated with the military. Historians reason that the close concentration of under-nourished and debilitated troops during World War One facilitated the rapid transmission of a new strain, particularly after demobilization when troops returned to their home countries.

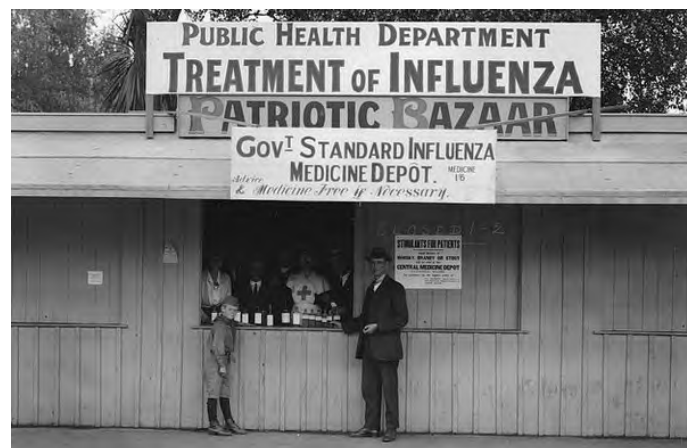
Regarding the geographical origin of the Spanish flu, Taubenberger and Morens state:

“Before and after 1918, most influenza pandemics developed in Asia and spread from there to the rest of the world. Confounding definite assignment of a geographic point of origin, the 1918 pandemic spread more or less simultaneously in 3 distinct waves during an \approx 12-month period in 1918-1919, in Europe, Asia, and North America...”

Deaths

The first recorded death was at the Fort Riley military camp in north-central Kansas in March 1918. In August a “more virulent strain” (Wikipedia) appeared simultaneously in Brest, France, in Sierra Leone in west Africa, and in Boston, Massachusetts.

This prompts one to ask (a) why another strain should suddenly emerge, (b) why the second strain should be more virulent than the first, and (b) why it should appear simultaneously in three locations that were so far apart? Again, these features do not fit the standard model.



It has been argued that, under wartime conditions, the total numbers who died from the new strain were not publicized lest they give comfort to the enemy. However, the War ended in November 1918, six months after the first flu-induced fatality, so there was plenty of time thereafter to collate and publish accurate figures. The fact that this was not done is very surprising. After all, if the number of deaths was as high as alleged, and if the scourge could conceivably strike again, then there was every incentive to compile and maintain proper records.

As a result we have a situation today where no-one actually knows for sure how many died in the great pandemic of 1918-1919. A few estimates, made after 1990, put the death toll worldwide at close to 50 million – out of a total world population of 1,800 million. But this figure far exceeds the commonly accepted figure of a half century ago, which was in the region of 5-10 million.

The influenza virus

According to medical experts all influenza pandemics since 1919, other than those from an avian source, have been caused by descendants of the 1918 virus. For this reason the 1918 virus is regarded as the ‘mother’ of all pandemics.

The cause of influenza per se was not discovered until the 1930s, when closely related influenza viruses (now known as H1N1 viruses) were isolated, first from pigs and shortly thereafter from humans. Until this discovery was made, medical science had been working on the hypothesis that it was caused by a bacillus.



Major outbreaks of flu ever since have been studied to determine how new strains evolve and why some strains are more pathogenic than others. Since no two strains are the same, scientists can tell whether an outbreak occurred naturally or whether an earlier strain was reintroduced (or “released”) into the environment. Taubenberger and Morens referred to an actual instance of this but made no further comment:

“With the appearance of a new H2N2 pandemic strain in 1957 (“Asian flu”), the direct H1N1 viral descendants of the 1918 pandemic strain disappeared from human circulation entirely, although the related lineage persisted enzootically in pigs. But in 1977, human H1N1 viruses suddenly “reemerged” from a laboratory freezer. They continue to circulate endemically and epidemically.”

In a paper published in the journal of the *American Society of Microbiology* in August 2015, M Rozo and G K Gronvall (‘The Reemergent 1977 H1N1 Strain and the Gain-of-Function Debate’) took a closer look at the same “freezer” incident and tried to tease out its implications:

“The 1977-1978 influenza epidemic was probably not a natural event, as the genetic sequence of the virus was nearly identical to the sequences of decades-old strains. While there are several hypotheses that could explain its origin, the possibility that the 1977 epidemic resulted from a laboratory accident has recently gained popularity ... we revisit the evidence that the 1977 epidemic was not natural and examine three potential origins: a laboratory accident, a live-vaccine trial escape, or deliberate release as a biological weapon.”

This must be one of the few occasions in a peer-reviewed medical research paper where the “deliberate release [of] a biological weapon” was treated as a plausible cause of a known disease.



Answering a basic question

After a hundred years of research, medical science has yet to answer the most basic question: Why did the 1918 virus cause so many fatalities? All of its apparent descendants were significantly less pathogenic.

It is notable that most of the fatalities worldwide occurred within a fairly narrow timeframe, between September 1918 and March 1919. Surprisingly, it was much less lethal in the first half of 1918 and must therefore have mutated to a more severe form simultaneously in different parts of the world in the second half of the year. This cannot be explained using the standard model of epidemiology. As Taubenberger and Morens noted: “What gave the 1918 virus the unprecedented ability to generate rapidly successive pandemic waves is unclear.”

Another paradoxical feature

In addition to these paradoxical features, the profile of the fatalities caused by the pandemic differed from that of every other flu outbreak in history, either before or since. Normally the curve is “U” shaped, with most of the fatalities occurring in children (whose immune systems are not yet fully developed) and the elderly (whose immune systems are often compromised). The curve for the 1918 pandemic, however, was “W” shaped, with a remarkably high incidence of fatalities occurring among healthy young adults.

For persons in the age range 15-34 years, the risk of death was more than 20 times greater than that observed in other outbreaks. (Interestingly, this age bracket – 15-34 – corresponds closely to the age for military service at that time.) In fact, the risk of dying from the virus during the 1918 pandemic was greater among persons aged under 65 than it was for those aged over 65.

Some medical scientists have tried to account for this striking anomaly by blaming such deaths on a ‘cytokine storm’. This is a technical term for an excessive inflammatory response by the body’s immune system to an invading pathogen. They argued that the virus triggered a cytokine storm in many patients and that those whose immune systems were strongest – not weakest – suffered the greatest damage.

This is certainly a gymnastic piece of reasoning, but it hardly qualifies as a serious scientific explanation. It contradicts much of what we know about the immune system and the way the body responds to environmental stress. Furthermore, the very high death rate was caused mainly by severe respiratory infections – infections in a specific location – not by organ failure in other parts of the body.



Transmissability

The human-to-human transmissability of the 1918 virus was extremely high, far greater than that seen in any other outbreak before or since. It is estimated that roughly one person in every three fell ill with the virus, though most went on to exhibit symptoms that differed little from those seen in other flu outbreaks.

The disease attacked the respiratory tract. Pneumonia is the most serious complication and the main cause of mortality during an outbreak. It should be noted that the virus itself is never the direct cause of death. Rather it seemingly impairs the ability of the immune system to fend off the bacteria that causes pneumonia.

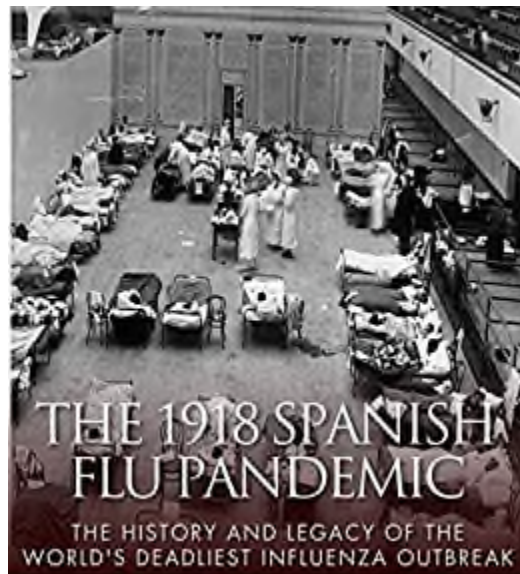
Ineffective vaccines

Most popular accounts of the 1918 pandemic fail to mention the use of vaccines. It is not mentioned, for example, in the main Wikipedia article on the Spanish Flu.

As one expert stated: “Many vaccines were developed and used during the 1918–1919 pandemic. The medical literature was full of contradictory claims of their success; there was apparently no consensus on how to judge the reported results of these vaccine trials.” – J M Eyler, *The State of Science, Microbiology, and Vaccines Circa 1918*, 2010.

He speaks of them as ‘vaccine trials’ but in reality they were no more than unregulated experiments on misinformed human subjects.

Many drug companies, large and small, saw the opportunity to sell one or more of their products as prophylactics against flu. These included vaccines which, as Eyler noted, “were of undisclosed composition.” The prices charged for these were often excessive and for some producers it was a lucrative business. Some of the vaccines were newly developed while others were pre-existing products of undisclosed composition endorsed by prominent physicians.



Early in the pandemic, many vaccines were developed using a bacillus, known as Pfeiffer's bacillus, as the base ingredient. These bacillus-based vaccines included the Park vaccine, which was approved by the New York Department of Health and used widely by physicians and in the military; a vaccine developed by Tulane University; a vaccine developed by Tufts Medical School in Boston, which was promoted both as a preventative and a treatment for influenza; and a vaccine developed by the University of Pittsburg based on 13 strains of the Pfeiffer bacillus.

Eyler states: “In the crisis atmosphere of the pandemic, the Pittsburgh vaccine developers isolated their strains, prepared the vaccine, tested it for toxicity in some laboratory animals and in two humans, and turned it over to the Red Cross for use in humans – all in one week.” What could possibly go wrong?

Some private physicians also developed vaccines on the assumption that Pfeiffer's bacillus was the cause of influenza. One physician in New York allegedly isolated 17 strains of the bacillus from 17 patients and developed a heat-killed vaccine to be administered in three doses.

Vaccine contents

In addition to an attenuated or heat-killed form of one or more strains of the Pfeiffer bacillus, these vaccines also typically contained pneumococci, streptococci and staphylococci, and “even unidentified organisms recently isolated in the ward or morgue” (Eyler). Again we ask, What could possibly go wrong?

The most widely used vaccine of all was the one developed by Edward C. Rosenow of the Mayo Clinic's Division of Experimental Bacteriology. It was adopted by the city of Chicago and widely distributed in the upper Midwest.

The view widely shared among medical practitioners and the public at large was that the vaccines, or some of them at least, were effective in preventing flu: “Almost without exception, those reporting on the use of these Pfeiffer's bacillus vaccines reported that they were effective in preventing influenza.” (Eyler) However, in a rare instance where a properly controlled study was carried out, it was found that Rosenow's vaccine, the one that was most widely used, offered no protection whatsoever. The American Public Health Association was obliged to admit that, since the cause of influenza was unknown, there was no scientific basis to any of the vaccines then in use.



Unanswered questions from the 1918 pandemic

Events in Wuhan require that we have some grasp of what happened in 1918. Many authoritative claims are being made by health authorities today, including the World Health Organization, which sound far less convincing when examined in the light of the Spanish Flu pandemic. Despite a century of research we still do not know -

- why the Spanish flu had such a high fatality rate;
- why it was so contagious;
- why it appeared simultaneously in different geographical regions;
- why it mutated into a much more dangerous strain within six months;
- why this mutation occurred simultaneously in two locations;
- and why it caused so many deaths in the age bracket 15-34.

In addition to these important questions, we still don't know why many of the victims succumbed so quickly to the disease. According to newspaper reports at the time, some victims died within 24 hours of exhibiting their first symptoms. Nor do we know what role the military in Europe and America played in either hindering or promoting the pandemic.

In the course of our examination we have also learned that the H1N1 strain had disappeared for decades and only emerged again in 1977, with the same genetic structure. This meant it had been in stored in a laboratory during all that time and then released, either deliberately or by accident.

1977 Russian Flu Pandemic

"By January 1978, the virus had spread around the world. From November 1977 through mid-January 1978 the population younger than 25 years in the Union of Soviet Socialist Republics experienced a widespread epidemic of mild influenza (Russian flu) caused by an H1N1 virus similar to the virus that circulated worldwide during the early 1950s."

– www.globalsecurity.org

Questions we need to ask about the Wuhan coronavirus

We are now in a better position to evaluate the reports we are receiving from the Chinese authorities and the World Health Organization about the Wuhan outbreak.

Perhaps the first thing we notice is that the so-called coronavirus is not very different in its behavior from the virus that causes influenza. Both are highly contagious and weaken the immune system in such a way that death is caused by pneumonia or respiratory failure. Consider, for example, the following definition from Wikipedia:

"Coronaviruses are believed to cause a significant proportion of all common colds in adults and children. Coronaviruses cause colds with major symptoms, such as fever and sore throat from swollen adenoids, primarily in the winter and early spring seasons. Coronaviruses can cause pneumonia – either direct viral pneumonia or a secondary bacterial pneumonia – and may cause bronchitis – either direct viral bronchitis or a secondary bacterial bronchitis..."

If Covid-19 is "flu-like", both in its transmissability and in its impact on the human immune system, then it is just as likely to give rise to as many unanswered questions as the Spanish Flu pandemic of 1918. If the leading minds in epidemiology are still struggling with basic questions after a hundred years, we would be very foolish indeed to take at face value anything they say about Covid-19.

Here are just some of the questions we can ask about reports to date, questions which reveal just how little we can trust the Chinese government or the World Health Organization in this matter:

1. Why has there been no independent confirmation – in even a single case within China – that patients have died from a pathogen known as ‘Covid-19’? This is an obvious question and yet no-one at government level in the West seems to have raised it. Consider an analogous case: If the North Korean government claimed that thousands of their citizens were dying from an unknown virus, would the international medical community not first seek strong independent verification of the claim before implementing an emergency protocol? The Chinese Communist Party is no more reliable or trustworthy than the ruthless psychopaths who control N Korea.
2. Why did the WHO wait over two months before sending an investigative team to Wuhan? This failure is incomprehensible. How can the world be expected to believe anything the WHO says about Covid-19 when it has demonstrated a craven willingness to believe anything they are told by the Chinese authorities?
3. What does the Covid-19 test actually show? The WHO speaks of ‘confirmed cases’ but this is only meaningful if the test is one hundred percent reliable. It is clear from the inconsistent way passengers on quarantined cruise ships are being treated that no such test exists. What is more, the term ‘confirmed case’ has little or no meaning if the test gives a positive reading for someone who will never go on to (a) develop symptoms or (b) transmit the virus to others.
4. How can the Italian authorities claim to have confirmed cases of Covid-19 when they are unable to show how any of the individuals concerned came into contact with the virus? The first and most important principle in epidemiology is to establish the mode of transmission. If this cannot be done then either the illness is not connected to Covid-19 or the virus is being spread maliciously.
5. If the virus is highly contagious, as the Chinese claim, and millions of people have passed through infected regions in recent months, why has the disease not spread more widely? An outbreak of pandemic flu in Wuhan would have reached virtually all parts of the world within 6-8 weeks. One would therefore expect Covid-19 to have already caused thousands of deaths outside of China, and yet the official death toll in other countries is only 21 (as of 23 February).

6. Is it purely a coincidence that the first city in the world to have a 60 GHz 5G network was Wuhan, and that this went live in the fall of 2019?
7. Is it purely a coincidence that the cruise liner, *Diamond Princess*, which was quarantined with multiples cases of coronavirus, is fully equipped with the latest wi-fi technology, including 5G?
8. How can a coronavirus, which belongs to a family of viruses that are found in human throat flora and are widespread in the environment, suddenly turn into a lethal, highly contagious pathogen?
9. Is it purely a coincidence that millimetre-length microwaves – the kind produced by 5G technology – can cause the sudden onset of respiratory health problems in humans? At the 60 GHz wavelength they cause the energy in oxygen molecules to spike dramatically and interfere with the uptake of oxygen by the haemoglobin in our blood. A person bathed in 5G radiation at close proximity would collapse for lack of oxygen. It is hard to distinguish the respiratory distress caused by 60 GHz radiation from the respiratory problems experienced by patients with the so-called ‘Covid-19’ virus.
10. Why are the virus tests conducted almost exclusively by the WHO? Why is there no independent verification of the test results?

5G Radiation

“At 60 GHz, Oxygen molecules in the atmosphere interact with the RF [radio frequency] signals to cause significant attenuation. Due to this attenuation the 60 GHz band is not a good frequency to use for long-range radar or communication applications. At 60 GHz O₂ can cause an attenuation of up to 10 dB/km...However, [since] this attenuation only really matters in long-range communications, the 60 GHz band can still be used for short-range communications, such as local wireless area networks.” – **www.everythingrf.com**, 17 August 2017

Note: The ‘attenuation’ is caused by the absorption of RF energy by O₂ molecules in the atmosphere. The same absorption mechanism can also interfere with our respiratory system – our oxygen intake – and cause serious health problems.

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CONCLUSION

It is possible to answer our 10 questions satisfactorily only if the lethal pathogen known as Covid-19 is in reality a psychological weapon, not a biological one.

It is doubtful whether more than a small percentage of the population would find this believable. The propaganda campaign behind Covid-19 is so intense that, even when presented with the type of evidence we have considered here, most people would scoff at the notion. The fear generated by the Covid-19 campaign, with non-stop coverage in the media, is intended to shut down all rational thought.

<p>Do you notice any similarities between the naval mines on the left and the 'coronavirus' on the right? The one on the left is a stock image of fear and instant death. The one on the right, which is purely imaginary, has been selected for the same purpose.</p>	

A few weeks ago, when we published our earlier paper on this topic, we were prepared to entertain the bio-weapon hypothesis on the basis of the information then available. However it is becoming increasingly clear that the official narrative is full of holes. While we cannot prove that the Wuhan plague is a masterful deception, our analysis points emphatically in that direction.

As we have noted in previous papers, the cabal behind the New World Order need something to take the blame for the coming collapse of the international banking system. It was already set to implode before the so-called Wuhan virus appeared on the scene. The pandemic will provide a very convincing explanation for the collapse, one that the public will readily accept. After all, it is shutting down industrial production all over China, curbing consumption in major markets, interrupting supply chains to countless businesses outside of China, and placing intolerable strain on financial credit lines.



A real biological pandemic would achieve the same result, but would be much harder to steer. The masterminds behind the NWO like to control every step in their plan and leave nothing to chance. An imaginary disease can crop up wherever they want, whenever they want, and infect as many people as they want. It can enable them to create as much fear as they feel is needed and introduce draconian laws to restrict or micro-manage human activity anywhere on earth. An imaginary disease will never infect their own people, nor will it get out of control and generate unintended effects. What is more, it won't mutate and die off, leaving the cabal with a lot of unfinished business. In short, an imaginary disease is even more potent than a real one.

Alas, the economic earthquake that will result for all of this will not be imaginary, and the tsunami of pain and suffering that will follow in its wake will be all too real.

We are about to enter a time when we will see grown men cry.

Christians will now need to trust in God and in His Mercy more than ever before. A great many troubled and distressed souls will look to us for guidance, comfort and support. If we allow ourselves to be thrown off balance by the great wave of fear which the Enemy is generating, we will not be of much use to our fellow man.

The saints will need to pray for and strengthen one another. They will also need to come together more frequently and worship with genuine joy the wonderful God who made us – **“In whose hand is the soul of every living thing, and the breath of all mankind.” (Job 12:10).**

The powers of darkness can wail all they want, but they cannot touch us.

May the LORD bless you and watch over you.

“Behold, a whirlwind of the LORD is gone forth in fury, even a grievous whirlwind: it shall fall grievously upon the head of the wicked. The anger of the LORD shall not return, until he have executed, and till he have performed the thoughts of his heart: in the latter days ye shall consider it perfectly.” – Jeremiah 23:19-20

**Jeremy James
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February 25, 2020**

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